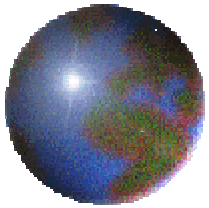


GLOBAL SYSTEM ISSUES RELATED TO PERFORMANCE OUTCOMES MEASUREMENT

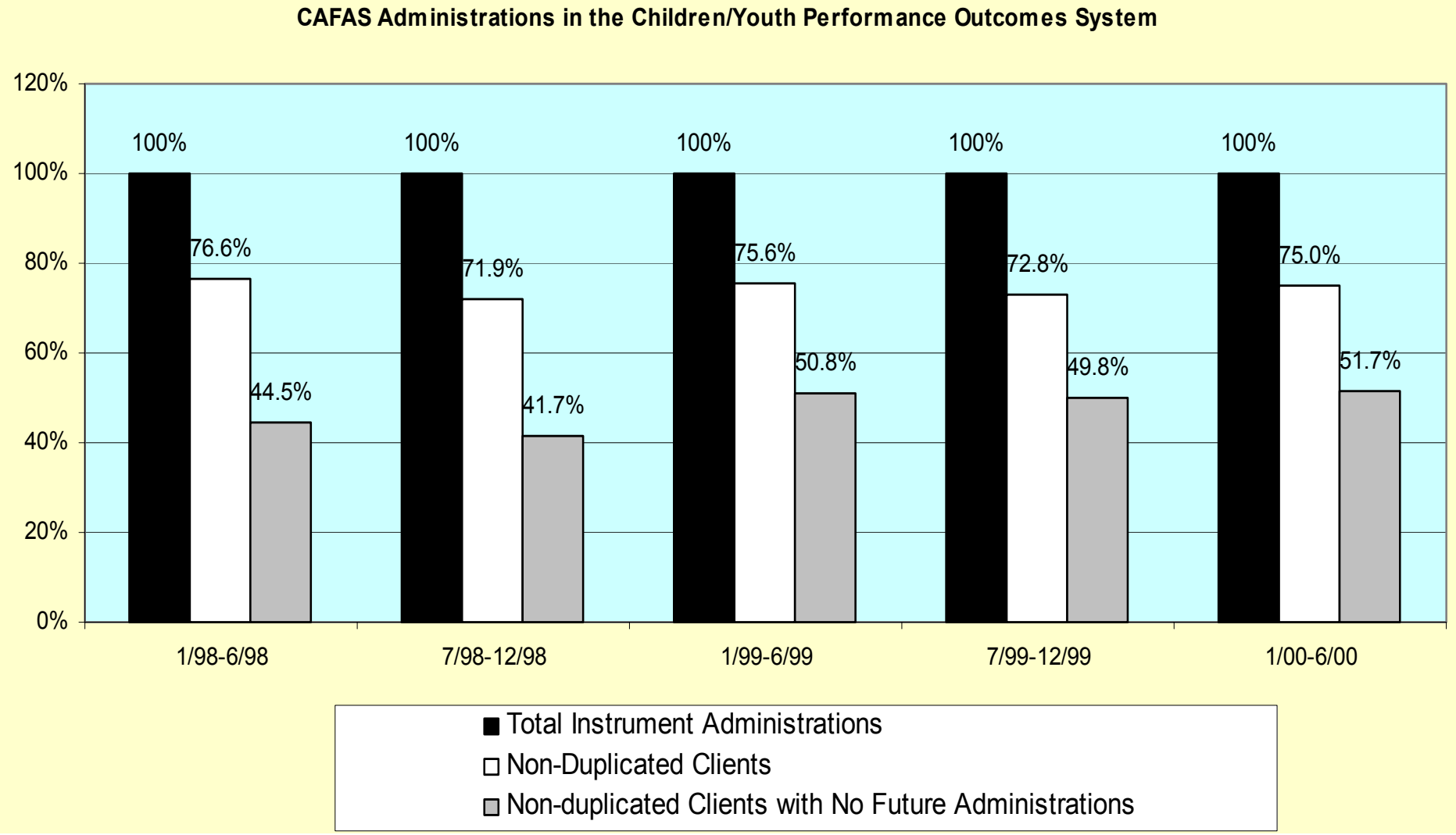
Some Identified System Issues

- Identifying the Target Population is problematic (*easier to do retrospectively*)
- High levels of attrition w/current frequency of administration (*intake, annual & discharge*)
  - Longitudinal vs Cross-Sectional Data
- Delays in Capturing Rate of Change (*studies show most change happens early in treatment*)
- Current Model based on Clinical Utility (*concerns about applicability for outcomes*)
- Confusion regarding what are we trying to measure, for whom, and for what purposes?

Identifying the Target Population

- Definition = 60+ days of service, excluding med's only, crisis service, & individual provider network
- Impossible to identify these clients at the time they enter the county system
- Lack of consistency in reporting across state:
  - Some counties/providers/clinicians wait until 60 days to administer forms
  - Some counties/providers/clinicians administer to everyone to simplify process
- County staff need an operational definition to automate identification of clients for tracking and oversight purposes (*does not exist at this time*)

High Levels of Attrition



Service Patterns – (All Clients & All Types of Services)

- Client and Service Information System (CSI) data provides comparative ("best-case") data:
  - March 2001 184,496 non-duplicated clients

    Of these 184,496
  - Sept. 2000 104,740 (56.8%) were still receiving services
  - March 2000 69,537 (37.7%) were still receiving services
  - Sept. 1999 51,861 (28.1%) were still receiving services
  - March 1999 41,069 (22.3%) were still receiving services
  - Sept. 1998 33,147 (18.0%) were still receiving services

Delays in Capturing Change

- Initial administration of instruments is often delayed until:
  - Client is identified as part of target population (60 or more days in service)
  - Adequate information is gathered to accurately complete forms
- Researchers have indicated that most change occurs at early stages of treatment which are not usually captured due to these delays
- No simple solution

Frequency of Administrations May Lead to Non-representative Sample

- Administrations of performance outcomes instruments are at intake, annually, and at discharge
- Not many counties are using formal discharge processes, many clients leave the system/do not have planned discharges, so very few discharge administrations are completed
- Clients remaining in the system for annual administrations may not be representative of all clients (How much attrition is due to transiency or client dissatisfaction versus client significantly improving?)

Longitudinal vs Cross-Sectional

- For outcomes purposes, do we need individual, matched client data over time (longitudinal)? (*Attrition is very important problem since data quantities are small*)

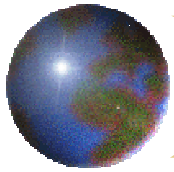
- Or will aggregate, system level data (cross-sectional) provide sufficient outcomes information? (*Attrition is not as important a problem since data quantities are much larger*)

Outcomes Initially Based on Clinical Assessment Utility Model

- Outcomes vs Clinical Utility
  - Can same instruments do both adequately?
    - State & Counties have expressed concern
    - Clinical Utility Based = more time & cost/less system-level outcomes (typically)
    - Outcomes Based = less time and cost/less clinical utility/more system-level data (typically)

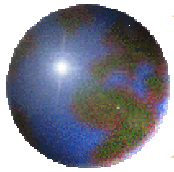
Outcomes Initially Based on Clinical Assessment Utility Model (continued)

- Outcomes vs Clinical Utility (continued)
  - Is it appropriate for the state to mandate assessment instrumentation?
    - Many counties/providers/clinicians want more flexibility in local assessment processes
    - Some counties/providers/clinicians don't want to give up any clinical utility in relation to outcomes measurement



What to measure, for whom, and for what purposes?

- Different Constituencies have very different data needs and purposes:
  - Legislature/Governor *[Functioning in Society/Reduced Costs]*
  - DMH *[Monitoring County Systems]*
  - State/Regional QIC *[System Improvements]*
  - Federal Government *[SAMHSA Indicators]*
  - Planning Council *[Client Satisfaction & Improvement]*
  - County Administrators *[Improved Efficiency/Program Efficacy]*
  - County Clinicians *[Clinical Utility]*

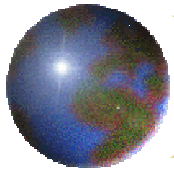


What do we really need to measure for statewide outcome purposes?

- Lack of Clarity (*Groups & Individuals all have different ideas*)
- Of the identified constituencies, whose data needs have the highest priority? Why?
- What is really required/needed versus what is desired? What criteria determines this?

Impact of Economic Slow Down

- "Things are going to be really dicey. I think what we are going to get is more of a V- shaped business cycle. But there are always losses in a recession, and so I think it is going to make both the current year and especially the budget year (2002-03) extremely difficult.“ -Ted Gibson (Chief Economist for the California Dept of Finance for the last 15 years)
- Any solutions to these system issues must take into account that we are in a time of diminishing resources
- System modifications must reduce and not increase the time and costs involved at all levels (DMH, County, Providers)



Potential Areas for Changes

- Outcomes Instrumentation
- Target Population
- Administration Methods
- Frequency of Data Collection

Changing Instrumentation

- Potential Benefits:
  - Increased Outcomes Related Data to DMH
  - Less Time/Cost
- Potential Deficits:
  - Less Clinical Utility
  - Requires System Infrastructure Changes
- Other
  - By itself, it does not resolve many of the Identified System Issues

Changing Target Population

- Potential Benefits:
  - Clarify the population of relevance to outcomes
  - Provide more specific operational definition
- Potential Deficits:
  - May require changes to county system/methods
- Other
  - Lack of Standard Methods between Counties make statewide operational definitions difficult
  - By itself, it does not resolve many of the Identified System Issues

Changing Administration Methods

- Potential Benefits:
  - Increased validity across state as methods are more standardized
- Potential Deficits:
  - May require changes to county system/methods
- Other
  - Difficulties in implementing/administrating (e.g., cannot provide info. if not yet available)
  - By itself, it does not resolve many of the Identified System Issues

Changing Administration Frequency

- Potential Benefits:
  - Reductions in High Attrition Rate (e.g., if 6 months administration was required)
- Potential Deficits:
  - May require changes to county system/methods
  - Increases county workload (not advisable with current economic outlook)
- Other
  - By itself, it does not resolve many of the Identified System Issues

Combination of Changes

- Example #1:
  - Change Instrumentation
  - Change Target Population
- Potential Benefits:
  - Reduced time/cost
  - More focused on clients of interest related to outcomes
- Potential Deficits:
  - Changes to county system/methods/infrastructure
- Other
  - Still does not resolve many of the Identified System Issues

Combination of Changes (continued)

- Example #2:
  - Change Instrumentation & Target Population
  - Change Administration Frequency (add 6 month administration)
- Potential Benefits:
  - Reduced time/cost per single administration
  - More focused on clients of interest related to outcomes
  - Reduced Attrition (increased longitudinal data)
- Potential Deficits:
  - Increased time/cost of additional administrations
  - Changes to county system/methods/infrastructure
- Other
  - Still does not resolve some of the Identified System Issues

Combination of Changes (continued)

- Example #3:
  - Change Instrumentation & Target Population
  - Change Administration Methods and Frequency
  - e.g., take 1 or 2 week samples of all clients every 6 months
- Potential Benefits:
  - Reduced time/cost & much less intrusive to clinical practice
  - Provides information on broader level of clients for comparative purposes
  - Provides both cross-sectional and longitudinal data (see next slide)
  - Allows for more flexibility in data collection related to clinical utility and county quality improvement at the local level
- Potential Deficits:
  - Changes to county system/methods/infrastructure

Combination of Changes (continued)

- Example #3 (continued):